STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	01	COMPLETED	
		155198	B. WING		03/05/2012	
NAME OF I	PROVIDER OR SUPPLIE	R		ADDRESS, CITY, STATE, ZIP CODE		
MARQUE	ETTE			OWNSHIP LINE RD NAPOLIS, IN 46260		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIE)	NCY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		
TAG	REGULATORY OI	R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE	
K0000						
			170000	1	,	
	A Life Safety Code Recertification and		K0000	The creation and submission		
		Survey was conducted by		this plan of correction does no constitute as an admission of	<b>I</b>	
	the Indiana State	e Department of Health in		conclusion set forth in the	arry	
	accordance with	1 42 CFR 483.70(a).		statement of deficiencies or a	ny	
				violation of regulation(s).		
	Survey Date: 03	3/05/12				
		00010				
	Facility Number					
	Provider Number: 155198					
	AIM Number:	NA				
	G M1	C 1 : C. C. C.				
	*	Caraher, Life Safety				
	Code Specialist					
	Δt this I ife Safe	ety Code survey,				
		found not in compliance				
	•	ents for Participation in				
	•	•				
	-	FR Subpart 483.70(a),				
	1	n Fire and the 2000 edition				
	of the National					
		FPA) 101, Life Safety				
	` ''	napter 19, Existing Health				
	Care Occupanci	es and 410 IAC 16.2.				
	This two story b	ouilding with a basement				
	-	to be of Type II (222)				
		d was fully sprinklered.				
		· ·				
	_	a fire alarm system with				
		in the corridors, areas				
	_	idor and resident rooms.				
	_	a capacity of 102 and had				
	a census of 89 a	t the time of this survey.				

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any defiency statement ending with an asterisk (\*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

PRINTED: 04/03/2012 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155198		(X2) MULTIPLE CO	ONSTRUCTION 01	(X3) DATE SURVEY COMPLETED 03/05/2012	
		100100	B. WING	ADDRESS CITY STATE OF CORE	30/00/2012
NAME OF F	PROVIDER OR SUPPLIE	₹		ADDRESS, CITY, STATE, ZIP CODE  OWNSHIP LINE RD	
MARQUE	ETTE			IAPOLIS, IN 46260	
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX TAG		ICY MUST BE PERCEDED BY FULL  LISC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE COMPLETION DATE
TAG	REGULATORT OF	CESC IDENTIF TING INFORMATION)	IAG	,	DATE
		Robert Booher, Life Safety			
	Code Specialist-Me	edical Surveyor on 03/08/12.			
	The facility was	found not in compliance			
	with the aforeme	entioned regulatory			
	_	evidenced by the			
	following:				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: S5QT21

Facility ID: 000105

If continuation sheet Page 2 of 13

	T OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155198	(X2) MU A. BUIL B. WING	DING	ONSTRUCTION  01	(X3) DATE : COMPL 03/05/	ETED
NAME OF P	ROVIDER OR SUPPLIER			8140 T0	ADDRESS, CITY, STATE, ZIP CODE OWNSHIP LINE RD IAPOLIS, IN 46260		
(X4) ID PREFIX TAG K0017	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
SS=E	Corridors are set walls constructed resistance rating partitions are onl passage of smoke buildings, walls passage of smoke buildings, walls passage of ceiling. (Corridor underside of ceiling permitted by Coostations, waiting activity spaces munder certain corridors by nonshop is fully spring 19.3.6.2.1, 19.3.6.2.1, 19.3.6.2.1, 19.3.6.2.1, 19.3.6.2.1, 19.3.6.2.1, 19.3.6.2.1, 19.3.6.2.1, Exception the corridor partitions capable of smoke, or met 19.3.6.1, Exception compartments prapproved, supervisystem shall be punlimited in size provided the follow. The spaces are sleeping rooms, the spaces are sleeping rooms, the spaces are sleeping rooms, the spaces compartment are serviced to supervision states are sleeping rooms, the spaces are sleeping rooms, the spaces compartment are serviced to supervision spaces.	ation and interview, the ensure 1 of 3 open use and floor was separated by smoke resistant e of resisting the passage an Exception. LSC on #1: Smoke otected throughout by an ised automatic sprinkler ermitted to have spaces open to the corridor, owing criteria are met: e not used for patient reatment rooms, or  (b) The corridors onto open in the same smoke protected by an ensure automatic smoke	K00	17	K017  What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: The Family Room involved in alleged deficient practice has been protected throughout by (4) quick response sprinklers a was promptly equipped with a smoke detector upon identification of this concern. See "Attachment K017A, FR Smoke Head".  How other residents having to potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken: All residents have the potential be affected by the alleged	this four and the e e e	04/04/2012

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: S5QT21

Facility ID: 000105

If continuation sheet

Page 3 of 13

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) D.			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	a. Building 01			COMPLETED	
		155198	B. WIN			03/05/2012	
		<u> </u>			ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	₹			OWNSHIP LINE RD		
MARQUI	ETTE				APOLIS, IN 46260		
(X4) ID		TATEMENT OF DEFICIENCIES		ID PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	`	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'		
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE	
	compartment in	which the space is			deficient practice. The Family		
	located is protected throughout by quick				Room involved in this alleged		
	response sprinkl	ers. (c) The open space is			deficient practice was promptly equipped with a smoke detection		
		electrically supervised			upon identification of this		
	-	e detection system, or the			concern.		
		ranged and located to					
	•	•			What measures will be put in	to	
	allow direct supervision by the facility staff from a nurses' station or similar space. (d) The space does not obstruct access to required exits. This deficient				place or what systemic		
					changes will be made to		
					ensure that the deficient		
					practice does not recur:		
	practice could affect any resident, staff or visitor in the vicinity of the Family Room				A full inspection of the Health Center was performed to ensu	uro.	
					that this alleged deficient pract		
	by Room 217 on	the second floor.			was isolated to the area identif		
					during the survey. The Family	,	
	Findings include	<b>:</b> :			Room involved in this alleged		
					deficient practice was promptly		
	Based on observ	ation with the Plant			equipped with a smoke detect	or	
		a tour of the facility from			upon identification of this concern.		
	_	-			concern.		
		20 p.m. on 03/05/12, the			How the corrective action(s)		
		Room 217 on the second			will be monitored to ensure t	he	
	^	he corridor due to the			deficient practice will not rec	ur,	
		walls and doors and is not			i.e., what quality assurance		
	1 *	electrically supervised			program will be put into plac	e:	
	automatic smoke	e detection system.			Maintenance personnel will randomly inspect the Health		
	Exception #1(b)	of LSC 19.3.6.1 was not			Center smoke heads for prope	er	
	met because the	Family Room is not			placement and function month		
	protected by an	electrically supervised			at a minimum for three months		
	automatic smoke	e detection system, or			and quarterly at a minimum		
		hout by quick response			unless determined by the QA		
	sprinklers. Based on interview at the time				Committee.		
	^	he Plant Director					
	-	ne Family Room by Room					
	_	•					
	_	e second floor corridor					
	and is not provid	led with smoke detectors					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: S5QT21

Facility ID: 000105

If continuation sheet Page 4 of 13

PRINTED: 04/03/2012 FORM APPROVED OMB NO. 0938-0391

		XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155198	(X2) MULTIPLE CC  A. BUILDING  B. WING	01		
NAME OF E	PROVIDER OR SUPPLIER ETTE		8140 T	ADDRESS, CITY, STATE, ZIP CO OWNSHIP LINE RD IAPOLIS, IN 46260	DE	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES  CY MUST BE PERCEDED BY FULL  LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE AP DEFICIENCY)	ECTION OULD BE PROPRIATE	(X5) COMPLETION DATE
	or quick response	e sprinklers.				
	or quick response 3-1.19(b)	e sprinklers.				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: S5QT21

Facility ID: 000105

If continuation sheet

Page 5 of 13

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A RIIII	A. BUILDING 01			COMPLETED	
		155198	B. WIN			03/05/2	2012	
NAME OF B	DOLUBED OF GUIDNIE				ADDRESS, CITY, STATE, ZIP CODE			
NAME OF P	PROVIDER OR SUPPLIER	L		8140 T	OWNSHIP LINE RD			
MARQUE					IAPOLIS, IN 46260			
(X4) ID		TATEMENT OF DEFICIENCIES		ID PROVIDER'S PLAN OF			(X5)	
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION	
TAG K0038	NFPA 101	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	-	DATE	
SS=F		ODE STANDARD						
33-1		ranged so that exits are						
	readily accessible at all times in accordance							
	with section 7.1.	19.2.1						
	Based on observ	ations and interview, the	K00	38	What corrective action(s) wil	ı	04/04/2012	
	facility failed to ensure 7 of 8 exit door				be accomplished for those			
	electromagnetic	locks remained unlocked			residents found to have been affected by the deficient practice: Previously, any			
	while the fire ala	rm was activated. LSC						
	19.2.1 requires every aisle, passageway, corridor, exit discharge, exit location, and access to be in accordance with Chapter 7. LSC 7.2.1.6(a) requires doors with				detection of smoke would trigg	ger		
					alarms in all separate areas of			
					Marquette. Late 2011, contrac	tors		
					were hired to segregate the alarms in each area in order to	、		
		rrangements such as			alert only those in potential	´		
		locks to unlock upon			danger. At the time of this			
		pproved fire alarm			survey, contractors still had the			
	I	in accordance with LSC			SNF area exit doors triggered	to		
		ent practice affects all			release when smoke was detected in the Assisted Living	,		
		nd visitors needing to exit			area. Upon identification of th			
		the first and second			deficiency, contractors properl			
	floors.	the first and second			programmed the electromagne			
	110013.				locks to unlock upon actuation the fire alarm system. See	of		
	Findings include				Attachment K038A, Door Worl	k		
	Tindings include	•			Order. How other residents	``		
	Based on observ	ations with the Plant			having the potential to be			
		a tour of the facility from			affected by the same deficier			
		20 p.m. on 03/05/12, the			practice will be identified and			
		•			what corrective action(s) will be taken: All residents residing			
	_	locks on all second floor			the Health Center have the	9 "'		
		exits, except for the			potential to be affected by the			
		id not release and remain			alleged deficient practice. Upo			
		he fire alarm was			identification of the deficiency,			
		p.m. Based on interview			contractors properly programn the electromagnetic locks to	ieu		
		observations, the Plant			unlock upon actuation of the fi	re		
	Director acknow	•			alarm system. What measures			
	electromagnetic	locks on all second floor						

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: S5QT21

Facility ID: 000105

If continuation sheet

Page 6 of 13

PRINTED: 04/03/2012 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION IDI	ENTIFICATION NUMBER: 55198	A. BUILDING  B. WING	01 	COMPLETED 03/05/2012
NAME OF I	PROVIDER OR SUPPLIER		STREET A 8140 TO INDIAN		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	EMENT OF DEFICIENCIES MUST BE PERCEDED BY FULL CIDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	(X5) COMPLETION DATE
	and all first floor exmain entrance, did unlocked when the activated.  3.1-19(b)	not release and remain		will be put into place or what systemic changes will be ma to ensure that the deficient practice does not recur: During random fire drills, maintenance personnel will randomly check ensure that doors equipped will electromagnetic locks unlock upon actuation of the fire alarm system. This validation will be documented on facility fire drill form. See Attachment K038B, Fire Drill Form. How the corrective action(s) will be monitored to ensure the deficient practice will not recise, what quality assurance program will be put into place. Administration will inspect and sign off on each fire drill form for proper completion or identification of concerns. Fire drills will occur and only once per week through April 27, 2012, and then conting per required schedule unless determined by QA review.	de  ng e to th  n e  c  cur g h

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: S5QT21

Facility ID: 000105

If continuation sheet

Page 7 of 13

	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155198		LDING	01	(X3) DATE ( COMPL 03/05/	ETED
NAME OF F	PROVIDER OR SUPPLIER			8140 T	ADDRESS, CITY, STATE, ZIP CODE OWNSHIP LINE RD APOLIS, IN 46260		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	FATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
K0045 SS=E	Illumination of m discharge, is arra single lighting fix area in darkness emergency lighti section 7.8.) 1 Based on observation facility failed to exit means of egit failure of any sin would not leave to the facility from Therapy Exit and lot exit.  Findings include  Based on observation observation during a 11:40 a.m. to 2:2 exit means of egit Level Physical Temployee parkin equipped with or bulb. Based on it observation, the acknowledged or one bulb was pro-	ention and interview, the ensure lighting for 2 of 5 ress were arranged so the gle lighting fixture (bulb) the area in darkness. actice could affect any visitor needing to exit the Lower Level Physical I the employee parking  Ention with the Plant atour of the facility from 20 p.m. on 03/05/12, the ress from the Lower herapy Exit and the glot exit are each are light fixture with one interview at the time of	K00	045	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: New fixtures have be installed at the observed 2 of sexits involved in the alleged deficient practice so the failure any single bulb will not leave the area in darkness. See "Attachment K045A, Egress Lighting". How other resident having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken: All residents have the potential to be affected by the alleged deficient practice. New fixtures have been installed at observed 2 of 5 exits involved the alleged deficient practice is the failure of any single bulb who not leave the area in darkness. What measures will be put in place or what systemic changes will be made to ensure that the deficient practice does not recur: New fixtures have been installed at observed 2 of 5 exits involved the alleged deficient practice is the failure of any single bulb who have the area in darkness. What measures will be put in place or what systemic changes will be made to ensure that the deficient practice does not recur: New fixtures have been installed at observed 2 of 5 exits involved the alleged deficient practice is the failure of any single bulb when th	een 5 e of he ts nt d lee in so the	04/04/2012

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: S5QT21

Facility ID: 000105

If continuation sheet

Page 8 of 13

PRINTED: 04/03/2012 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION	IDENTIFICATION NUMBER: 155198	(X2) MULTIPLE CO  A. BUILDING  B. WING	01	COMPLETED 03/05/2012			
NAME OF I	PROVIDER OR SUPPLIE ETTE	R	STREET ADDRESS, CITY, STATE, ZIP CODE  8140 TOWNSHIP LINE RD INDIANAPOLIS, IN 46260					
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE			
	3.1-19(b)			not leave the area in darkness How the corrective action(s) will be monitored to ensure to deficient practice will not red i.e., what quality assurance program will be put into place Random inspection of egress lighting around the Health Cer will take place three (3) times weekly through April 27, 2012 then weekly for four (4) weeks and then monthly if determine QA review. See "Attachment K045B, Egress Lighting Audit"	the cur, ce: nter c, d by			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: S5QT21

Facility ID: 000105

If continuation sheet

Page 9 of 13

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	a. Building 01			COMPLETED	
		155198		B. WING 03/05/			2012
			_	STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIER		8140 TOWNSHIP LINE RD				
MARQUE				INDIAN	IAPOLIS, IN 46260		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES		ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ГЕ	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
K0048 SS=E	There is a writter patients and for t of an emergency	ODE STANDARD  n plan for the protection of all their evacuation in the event  19.7.1.1  review and interview, the	what correct be accomplicated by a specific plan has been the following.		What corrective action(s) will	ı	04/04/2012
	facility failed to fire extinguishers safety plans for the requires written leading.	include the use of kitchen in 1 of 1 written fire the facility. LSC 19.7.2.2 mealth care occupancy shall provide for the			be accomplished for those residents found to have been affected by the deficient practice: The Health Center dhave a written plan for the protection of all patients and for their evacuation in the event of	oes or f an	
	(1) Use of alarms (2) Transmission department (3) Response to a	of alarm to the fire			emergency. In response to the alleged deficient practice, the plan has been modified to include the following statement: "The proper extinguisher should be		
	(4) Isolation of fi (5) Evacuation of	re			used for the proper fire. ABC extinguishers will handle most fires encountered in our buildings. An uncontrollable		
	(7) Preparation o evacuation (8) Extinguishme	f floors and building for			grease fire in the kitchen can be controlled by manually activating the hood suppression system (if not activated automatically) and		
	This deficient pra resident, staff and of the kitchen.	actice affects any d visitors in the vicinity			then by using the K extinguish located adjacent to the deep fr as a backup." <b>How other</b>	er yer	
	Findings include	:			residents having the potentia to be affected by the same deficient practice will be identified and what corrective		
	fire safety plan ti Preparedness Ma review with the I Administrator fro a.m. on 03/05/12	w of the facility's written tled "Disaster mual: Fire" during record Plant Director and the om 9:40 a.m. to 11:40 , the fire safety plan did se of ABC type fire			action(s) will be taken: All residents have the potential to affected by the alleged deficien practice. In response to the alleged deficient practice, the plan has been modified to inclute the following statement: "The proper extinguisher should be used for the proper fire. ABC	be nt	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: S5QT21

Facility ID: 000105

If continuation sheet

Page 10 of 13

PRINTED: 04/03/2012 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION IDENTIFICATION NUMBER:	(x2) MULTIPLE CONSTRUCTION  A. BUILDING  01		COMPLETED	
	155198	B. WING		03/05/2012	
NAME OF MARQU  (X4) ID  PREFIX  TAG	PROVIDER OR SUPPLIER  ETTE  SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PERCEDED BY FULL  REGULATORY OR LSC IDENTIFYING INFORMATION)	8140 TO\	PORESS, CITY, STATE, ZIP CODE WNSHIP LINE RD POLIS, IN 46260  PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	(X5) COMPLETION DATE	
	extinguishers and the K class fire extinguisher located in the kitchen in relationship with the use of the kitchen overhead extinguishing system. Based on interview at the time of record review, the Plant Director and the Administrator acknowledged the written fire safety plan for the facility did not include kitchen staff training to activate the overhead hood extinguishing system to suppress a fire before using either the ABC type fire extinguisher or the K class fire extinguisher.  3.1-19(b)		extinguishers will handle most fires encountered in our buildings. An uncontrollable grease fire in the kitchen can be controlled by manually activation the hood suppression system onto activated automatically) and then by using the K extinguish located adjacent to the deep from as a backup." What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: All maintenance and food service personnel will be educated regarding the updated policy. Continuing education will occu with newly hired maintenance food service personnel and annually thereafter for all maintenance and food service personnel. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be purinto place: The Quality Assurance Committee will revithe fire safety plan for complial and make updates as indicated by April 4, 2012.	e  oe  ng (if id er yer s  de  r and  e  ty ut  ew nce	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: S5QT21

Facility ID: 000105

If continuation sheet

Page 11 of 13

PRINTED: 04/03/2012 FORM APPROVED OMB NO. 0938-0391

AND PLAN	TOF DEFICIENCIES OF CORRECTION PROVIDER OR SUPPLIER	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155198		LDING G	ONSTRUCTION  01  ADDRESS, CITY, STATE, ZIP CODE	(X3) DATE S COMPL 03/05/	ETED
MARQUE					OWNSHIP LINE RD IAPOLIS, IN 46260		
		TA TEN TENT OF DEPLOYENCIES	-		T 40200		aus)
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
K0144 SS=F	Generators are in exercised under month in accorda 3.4.4.1.  Based on record facility failed to describe failed to d	essential electrical inspected at intervals of days and shall be I compliance with pecifications. Defective repaired or replaced in discovery of defects. PA 110, 6-3.6 requires batteries, including at intervals of not more upter 3-5.4.2 of NFPA 99 in record of inspection, ercising period, and inerator to be regularly evailable by the authority on. This deficient fect all residents, staff	K01	44	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: In response to the alleged deficient practice, the Generator Test Log has been modified to allow for documentation of Battery Visu Inspection and Electrolyte Levels. See Attachment K144 Generator Log. How other residents having the potentiat to be affected by the same deficient practice will be identified and what correctiv action(s) will be taken: All residents have the potential to affected by the alleged deficie practice. In response to the alleged deficient practice, the Generator Test Log has been modified again to allow for documentation of Battery Visu Inspection and Electrolyte Lev What measures will be put in place or what systemic changes will be made to ensure that the deficient practice does not recur: All maintenance personnel will be educated regarding the update Generator Log. Continuing education will occur with newly hired maintenance personnel side of the same o	al  e be nt  al els. nto	04/04/2012

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: S5QT21

Facility ID: 000105

If continuation sheet

Page 12 of 13

PRINTED: 04/03/2012 FORM APPROVED OMB NO. 0938-0391

	of correction identification number:  155198	A. BUILDING  B. WING	HION	(X3) DATE SURVEY  COMPLETED  03/05/2012	
NAME OF I	PROVIDER OR SUPPLIER	8140 TOWNSH	STREET ADDRESS, CITY, STATE, ZIP CODE 8140 TOWNSHIP LINE RD INDIANAPOLIS, IN 46260		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PERCEDED BY FULL  REGULATORY OR LSC IDENTIFYING INFORMATION)	PREFIX (EACI CROSS	PROVIDER'S PLAN OF CORRECTION H CORRECTIVE ACTION SHOULD BE I-REFERENCED TO THE APPROPRIA' DEFICIENCY)	2.112	
	Generator Test Log" documentation with the Plant Director and the Administrator during record review from 9:40 a.m. to 11:40 a.m. on 03/05/12, weekly emergency generator starting battery inspection records for the fifty two week period from 03/07/11 through 02/27/12 was not recorded. Based on interview at the time of record review, the Plant Director acknowledged weekly emergency generator starting battery inspection records for the fifty two week period from 03/07/11 through 02/27/12 was not recorded.  3.1-19(b)	determ respon Director be respon Director be respon Complete General Correct monitor deficite i.e., which was a superior of the Health Log on April 2 thereal weekly	per completion of this lognined by their job insibilities. The Plant or and/or his designee we ponsible for proper etion of the Health Centerator Log. How the etive action(s) will be ored to ensure the ent practice will not rechat quality assurance and will be put into place ealth Center Administration to Director will review to a weekly basis through 17, 2012, and then montifier unless continued inspection is determined QA Committee.	vill er eur, e: tor the	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: S5QT21

Facility ID: 000105

If continuation sheet

Page 13 of 13